STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E473	A. BUILDING _____ B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COFFEY COUNTY HOSPITAL LTCU	128 S PEARSON AVE WAVERLY, KS 66871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility identified a census of 27 residents. Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services for the facility environment and resident's living areas in 2 of 2 halls of the facility. Findings included: - During the environmental tour of the facility, on 11/18/13 at 11:30 AM, observation revealed the following areas in need of cleaning and/or repair: A.) East Hall 1.) Five resident rooms revealed closet doors that are scraped at handle level where the room door and the closet door collide when both open. 2.) One resident room revealed unfinished lumber, approximately 2" x 7", laying on the floor and runs the entire length of the room behind the beds and under the bedside stands. B.) West Hall 1.) One resident room revealed screw holes in the bathroom door, a gouge on the wall above the	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 baseboard and a watermark, approximately 6" in size on one ceiling tile, in the corner of the bathroom. 2.) One resident room revealed divits, too numerous to count, on 4 tiles on the floor close to the bathroom door. 3). Two resident rooms revealed closet doors that are scraped at handle level where the room door and the closet door collide when both open. 4). One resident room revealed unfinished lumber, approximately 2" x 7", laying on the floor and runs the entire length of the room behind the beds and under the bedside stands. Maintenance staff M stated, on 11/18/13 at 11:50 AM that he/she was aware of the needed repairs and maintenence and that it was a work in progress. The facility failed to maintain an orderly and comfortable interior for the residents of the facility.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		

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F 278	Continued From page 2 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility identified a census of 37 residents with 13 sampled. Based on observation, interview, and record review, the facility failed to complete an accurate comprehensive assessment for one resident (#21) for ADL's, and 1 resident's (#12) for range of motion. Findings included: - Review of resident #12's clinical record, revealed the resident admitted to the facility on 9/16/13, with the following diagnoses; arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), Parkinson's (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) , and chronic (persisting for a long period, often for the remainder of a person ' s	F 278		

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F 278	Continued From page 3 lifetime) pain. The Annual MDS (minimum data set), dated 10/23/13, revealed the resident had a BIMS (brief interview for mental status) score of 7, indicating severely impaired cognition. The resident required for ADL's (activities of daily living) total assist of 1-2 for all ADL's. The resident had functional limitation in range of motion to both upper extremity and lower extremity bilaterally. Mobility per wheelchair. The resident had a diagnoses of Parkinson's disease, and arthritis. The resident is on a scheduled pain medication regimen, had pain indicators of pain or possible pain, non-verbal sounds, vocal complaints, and facial expressions, indicators of observed daily. Restorative nursing programs for range of motion either passive or active, and splint or brace assistance lacked documentation the resident received these services. The quarterly MDS 3.0, dated 8/7/13, revealed the resident the had a BIMS score of 3, indicating severely impaired cognition. No change in ADL's, mobility per wheelchair, no change in functional range of motion, has Parkinson's and arthritis, pain unchanged. No further changes from the prior assessment. The CAA'S (care area assessment summary), dated 10/30/13, revealed for cognition: No significant changes. Good and bad days. When he/she is alert and comfortable she will answer questions better but only for short periods of time. Memory is impaired but family believes she does recognize them but converses less. For ADL's: Remains dependent with all ADL's. The care plan reviewed, on 10/30/13, documented the following:	F 278		

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F 278	Continued From page 4 Maintenance Care Flow Record-10/1/13 Goal: to maintain range of motion Frequency: 2-5 times a week, for at least 10-15 minutes each session Treatment: PROM to all extremities Chronic pain related to contractures, Parkinson, arthritis, --Assess pain per shift with Abbey scale and verbal scale --Be aware of non-verbal indicators of pain, such as grimacing, frowning, crying, etc. --Position change every 2 hours. --Offer non-medication interventions for reports of pain. --report to charge nurse indicators of pain --See MAR (medication administration record) for current medications. Review of the residents," Therapy Walk By", dated 8/14/13, documented the following: Use stand up lift/2 person assist, non-ambulatory, flexion contractures, maintenance for ROM (range of motion), 2-3 times a week, chronic pain, limits ROM, up in geri chair as tolerated. October 2013 Maintenance Care Flow Record documented the following: Name: #12 Goal: to maintain range of motion Frequency: 2-5 times a week, for at least 10-15 minutes each session. Treatment: PROM (passive range of motion) to all extremities. PROM to all extremities: documented done on the 1,2,3,4,8,9,10,12,13,14,15,17,18,22,23,24,26,27, 28,29,31.	F 278		

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Massage to all extremities as tolerated: done on the same dates as the PROM. Lacked documentation as to how many minutes or repetitions provided.

"Therapy Walk By", dated 11/13/13, documented the following: 2 person assist with transfer vest, non-ambulatory, flexion contractures, maintenance for ROM 2-3 times a week, chronic pain, limit ROM, up in geri chair as tolerates.

Review of the November Maintenance Care Flow Record documented the following:

Resident #12
Goal: to maintain range of motion
Frequency: 2-5 times a week, for at least 10-15 minutes each session.
Treatment: PROM to all extremities.

PROM to all extremities: documented done on the 1, 2, 4, 5, 7, 8, 10, 12, 13. Massage to all extremities as tolerated: done on the same dates as the PROM. Lacked documentation as to how many minutes provided.

Observation, on 11/14/13, 8:30 AM, revealed staff had just transferred the resident from geri chair to the bed. The resident resting quietly in bed with a wedge between his/her legs and one pillow under their heels to float, and and behind their back. The left hand has a gauze roll in it. The resident is alert and oriented to self, and reported he/she does not hurt at this time. The resident is right hand not as contractured as the left hand, and the ankles/feet with contractures, the legs are stiff along with his/her arms.

On 11/14/13 at 10:18 AM, observation revealed direct care staff L and F, provided care to the

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resident. the resident resting quietly in bed, position unchanged. The resident then transferred fireman style to the geri chair, by staff. The resident had pillow placed under right arm, and wedge between legs. The resident denies any pain.

On 11/14/13 at 2:18 PM, the resident resting quietly in bed with eyes closed, heels floated by pillow, wedge between the residents legs, pillow noted behind the residents back. The resident with pillow elevating the arms and the residents left hand with gauze roll in it. No signs or symptoms of pain noted.

ON 11/18/13 at 1:35 PM, direct care staff F started range of motion for the resident. The resident complaining of pain when asked. Direct care staff F reported the resident's pain to the nurse and the resident given PRN pain medication.

On 11/18/13 at 2:30 PM, the resident resting quietly in bed with eyes closed.

On 11/14/13 at 8:35 AM, direct care staff L reported, "We float the resident's heels with a pillow and place a wedge between his/her legs. He/she has pillows for positioning. We place one under his/her arm, and one or two behind his/her back. He/she receives range of motion."

On 11/14/13 at 10:20 AM, direct care staff F, reported, "I only do the resident 2-5 days a week. I don't always do restorative on back to back days. I document the minutes on the flow sheet. The flow sheet does not have area to document actual minutes, just initial that it has been done and to be done for 10-15 minutes. Licensed administrative staff A is over the restorative

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program and the physical therapist from the hospital comes in."

On 11/18/13 at 1:45 PM, direct care staff F, reported "The resident is saying no to range of motion."

On 11/18/13 at 2:00 PM, direct care staff F, reported, "The resident refused. She does that sometimes."

On 11/13/13 at 4:24 PM, licensed nursing staff N reported, "The resident receives restorative. Someday's he/she requires pain medication others he/she does not. It is on the care plan as to how often."

On 11/14/13 at 11:19 AM, licensed nursing staff D reported, "The nurses or the restorative aide, place a cotton roll in her palm, after I clean it. The resident receives maintenance range of motion, 2-3 times a week. It is painful at times, but has pain in general. They do not pre-medicate him/her, unless they see him/her in pain and then stop and medicate him/her."

On 11/18/13 at 2:38 PM, licensed administrative staff B reported, "The resident really enjoys having the massage done. He/she has a lot of pain. I did not mark the MDS because it does not change payment."

The facility failed to complete an accurate assessment, on the 10/23/13 comprehensive assessment, depicting the resident receiving range of motion.

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- The physician order sheet, dated October 2013, and signed by physician on 10/4/13, documented resident #21 admitted to facility on 7/30/11 with diagnosis of dementia (progressive mental disorder characterized by failing memory and confusion), hypertension (elevated blood pressure), arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), open reduction internal fixation of left hip (a surgical procedure for reducing a fracture or dislocation by exposing the skeletal parts involved), and neuropathy (a disease involving nerves which may affect sensation, movement, gland or organ function and other aspects of health).

Review of the annual MDS, dated 6/19/13, revealed a BIMS (brief interview of mental status) of 15 (score of 13-15 cognitively intact). ADL's (activities of daily living): independent in bed mobility, transfer, walk in room/corridor, locomotion on/off unit, dressing, eating, toilet use, and personal hygiene. Requires physical assistance of one staff for bathing. Uses a walker and is steady at all times. No functional limitation in ROM (range of motion). No falls noted.

Review of the quarterly MDS, dated 9/11/13, revealed a BIMS of 15 (score of 13-15 cognitively intact). ADL's: independent in bed mobility, transfer, walk in room/corridor, locomotion on/off unit, eating, toilet use, personal hygiene. Resident requires limited assist of one staff for dressing. Physical assist of one staff for bathing. Uses a

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F 278	Continued From page 9 walker and steady at all times. No falls noted. From 6/19/13 to 9/11/13 assessments for ADL's reveal a decline from Independent "0", with no setup or physical help from staff "0", to Limited assist "2" with one person physical assist "2" in the category of dressing. Review of the CAA (care area assessment), dated 6/26/13, revealed: ADL's - "no significant change". Review of the CAA, dated 7/24/12, revealed: "No significant changes. Requires minimal assistance of one aide for bathing and applying ted hose." Review of the care plan, last revised 9/18/13, revealed (the resident) does their own daily ADL's. Needs assistance of one staff with bath. Encourage to perform personal grooming. Brushing teeth, combing hair etc. Only assist as needed to encourage independence. Assist with bath. See that resident has supplies needed to do own ADL's. Review of the Total Plan of Patient Care Sheet, not dated, in care plan book reveals: Bladder: self control, no assist. Bowel: self control, no assist. Eating: feeds self. Locomotion: Walker ad lib, fully ambulatory (no assist level marked) Position: change by self Dress: self care (no assist level marked) Bath: Shower, assist On 11/13/13 at 7:55 AM, observed resident ambulate with walker from dining room to bedroom, went to bathroom and got into bed, covered with blanket to rest, all with no	F 278		

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assistance from staff.

On 11/13/13 at 11:34 AM resident observed getting out of bed from resting, put on shoes, ambulated with walker to dining room for lunch, all without assistance from staff.

On 11/18/13 at 3:18 PM observed resident ambulate to bathroom and back to bed using walker, did not call for staff or need assistance with ambulation or toileting.

On 11/13/13 at 8:03 AM, resident stated that he/she takes care of him/herself and rarely needs help with anything. Resident needs for staff assistance have not changed in any areas since admission. Resident states that he/she broke a hip about a year ago, and might have slowed down a little then, but still did everything for him/herself.

On 11/13/13 at 1:50 PM, direct care staff F stated "[The resident] needs help with showers and toileting, but that's not always, we might give choices for clothes sometimes, but as for actually getting dressed, [the resident] is independent. I've taken care care of [the resident] for 5 months. [The resident] is the same level of care today as when I started."

On 11/13/13 at 2:58 PM, direct care staff G stated, "[The resident] is independent. I've worked with [the resident] since [he/she] was admitted, there has been no decline in ADL's in any area. [The resident] dresses [him/herself].

On 11/18/13 at 8:25 AM, direct care staff L stated, "...[the resident] does pretty much everything for [him/herself]. That hasn't changed since [he/she] got here...as for [his/her] dressing,

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[he/she] is totally independent, [he/she] doesn't need any help in the morning getting dressed."

On 11/18/13 at 8:37 AM Licensed nursing staff D stated, "[The resident] has had no change in level of care. [The resident] is the same as when I started a year and a half ago. [The resident] dresses [him/herself] but needs a little assist in the bathroom with shower, but it's minimal. [He/she] really is independent."

Administrative nursing staff B, on 11/18/13 at 9:30 AM, stated, "to determine the level of ADL Care for the MDS, the CNAs (certified nursing assistants) fill out an ADL flow sheet during the observation look back time of 7 days, these are then destroyed after I do the MDS. Also, I use the nursing quarterly summary found in the chart. I use a combination of the two forms for my data to determine the level of care to code the MDS...When it comes to determining what to code in the MDS for ADL's, while I look at both the CNA flow sheet and the nurse summary...I definitely weigh more heavily on what the CNA's chart and have to say since they are the ones providing the actual care."

The nursing quarterly summary used for MDS collection data revealed:
Summary dated 8/31/13 revealed Functional status: Dressing: Independent and Bathing: Limited Assist.
Summary dated 6/8/13 revealed Functional status: Dressing: Independent and Bathing: Limited Assist.

Review of chart reveals a lack of ADL flow sheets for MDS lookback period.

The facility failed to complete an assessment that

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F 278	Continued From page 12 accurately reflects the resident's ADL status.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 27 residents, with 13 residents in the sample. Based on observation, interview and record review, the facility failed to develop an individualized comprehensive plan of care for resident #29 for use of bed rails. Findings included: - The POS (physician order sheet), for resident #29, dated and signed 10/01/2013, documented the following diagnosis of dementia, abdominal aortic aneurysm (a localized dilation of the wall of the aorta), and right hemiparesis (muscular	F 279		

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weakness of one half of the body).

The significant change MDS (minimum data set 3.0), dated 09/10/2013, documented the resident needs extensive assistance with ADL's (activity of daily living), such as bed mobility, transfers, dressing, eating, and personal hygiene. It also documented functional limitation in ROM (range of motion) to the lower extremity on one side.

The CAA (care area summary), dated 09/17/2013, ADL functional/rehabilitation potential documented the resident was admitted to hospital to have a thoracic stent placed regarding the aneurysm. There was a problem with the spinal anesthesia (spinal chord infract) and the result being that he/she has a partial paralysis (the loss of muscle function, sensation or both) of the right leg. He/she is unable to walk and can transfer with assist to a wheelchair. The CAA lacked documentation of the use of a side rail for mobility purposes.

The care plan, dated 10/02/13, documented the resident requires total maximum assistance with ADL's such as bathing, dressing and personal hygiene. The care plan failed to document use of a siderail for positioning.

The resident care sheet for the west hall revealed the resident is confused at times, needs assisting with meals, uses the wheel chair, ...transfers, stand lift with two assist and use of 1/2 rails.

Observation, on 11/12/2013 at 12:43 PM, the resident was positioned in the bed, a winged mattress in use as well as bilateral 1/4 bed rails at HOB (head of bed) in the up position.

Observation, on 11/13/2013 at 1:30 PM, revealed

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F 279	Continued From page 14 the resident was positioned in the bed on a winged mattress, bilateral 1/4 siderails at HOB, were in the up position. Observation, on 11/13/2013 at 4:00 PM, revealed the resident was positioned in the bed on a winged mattress, bed in low position, fall mat in place, call light in reach, bilateral 1/4 siderails in the up position at head of bed. On 11/13/2013 at 4:24 PM, License nursing staff N advised, when asked who uses side rails on their beds, "It is usually done in the care plan when they first come in, usually Administrative staff A or License nursing staff B assess that when someone first comes in." On 11/14/2013 at 1:15 PM, Direct care staff L advised, that the resident could turn himself/herself in the bed, and uses the rails to position him/herself. He/She could get up by self, that is why we use an alarm, the fall pads and a low bed. On 11/14/2013 at 3:43 PM, Direct care staff K advised, "He/she has 1/2 rails on the bed, he/she is a fall risk so there is a lower bed and pads on the floor. The rails are suppose to be up when they are in the bed." On 11/18/2013 at 8:25 am, License nursing staff D advised, "We determine if they [the residents] need them [the siderails] for independence in bed to help turn or position, on the resident care sheet that the CNA's [certified nurses assistants] carry, they indicate who has them [bed rails]. The nurses do the determination upon admission and if something changes in their functionality then we will reassess, but there is not no real assessment done."	F 279		

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F 279	Continued From page 15 The Policy provided entitled Comprehensive Care Plans, dated March, 2012, documented that the facility should develop an individual care plan for each resident to meet that resident's medical nursing, mental and psychosocial needs. The interim care plans will be initiated on admission after the initial assessment. The interdisciplinary team in conjunction with the resident, residents' family or representative as appropriate will meet no less than 21 days after admission and develop a care plan with objectives for the highest level of functioning that the resident may be expected to attain, based on the comprehensive assessment. The facility failed to develop a care plan to address the use of the siderails for this resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This Requirement is not met as evidenced by:
The facility identified a census of 27 residents, with 13 residents sampled. Based on observation, interview, and record review, the facility failed to review and revise care plans for 2 sampled residents, #1 for falls and #29 for range of motion.

Findings included:

- Review of the physician order sheet, dated September 2013, and signed 9/3/13, documented resident #1 admitted to the facility on 8/31/12 with diagnosis of chronic back pain (persisting for a long period, often for the remainder of a person ' s lifetime), Hypertension (elevated blood pressure), hyponatremia (a less than normal concentration of sodium in the blood), dementia (progressive mental disorder characterized by failing memory, confusion) with anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), glaucoma (an abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), bipolar (a major mental illness that causes people to have episodes of severe high and low moods), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

Review of the significant change MDS (minimum data set), dated 5/21/13, revealed a BIMS (brief interview of mental status) of 3 (0-7 severely impaired cognition). No behaviors noted. No wandering noted. ADL's- Extensive assistance of one staff for dressing, toilet use and dressing. Limited assistance of one staff for transfers. Supervision and setup help for eating.

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Independent in bed mobility, walk in room/corridor, locomotion on/off unit. Physical help of 1 staff for bathing. Uses walker, not steady, but able to stabilize without staff assist. On scheduled pain medications. Two falls, 1 injury and 1 non injury noted.

Review of the quarterly MDS, dated 8/14/13, revealed BIMS of 3 (0-7 severely impaired cognition). Verbal behavioral symptoms directed toward others occurred 1-3 days out of 7. Wandering occurred 4-6 days out of 7, but less than daily. ADL's- Extensive assistance of one staff for bed mobility, dressing, toilet use and personal hygiene. Supervision only for walk in room/corridor, locomotion on/off unit and eating. Independent for transfers. Physical help in part of bathing of 1 staff. Uses walker, not steady, but able to stabilize without staff assistance. On scheduled pain meds. Had two or more injury falls. Uses antipsychotic, antianxiety, antidepressant, diuretic 7/7 days.

Review of the CAA (care area assessment), dated 5/28/13, revealed:

Cognitive loss: BIMS 3. Periods of anxiety increasing, pacing, repetitive questions, difficult to redirect. Care plan revised to provide interventions.

ADL's: Has required increased assistance with dressing, personal hygiene, and transfers due to anxiety which is affecting cognition. Care plan revised.
Psychosocial well being: having increased anxiety, with both wandering and pacing. Unable to interest in any activities and difficult to re-direct. (The resident) will ask about going home and talk about leaving and has made an attempt to leave

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F 280	Continued From page 18 the facility. Mood/behavioral: Has exhibited increased hostility to staff trying to redirect or provide cares. Care plan revised. Falls: Remains at high risk for falls. Gait slow and unsteady. Last fall 4/24/13 moderate injury. Is independent with walker which (he/she) frequently forgets and leaves. Psychotropic drug use: medications have been adjusted frequently because of increasing behaviors and with the increase, becomes more lethargic. It is difficult to find the right balance and it is an ongoing process. During this observation period, PRN Ativan was required frequently. Review of the records revealed no MDS available from after the fall on 10/15/13. Review of the care plan, last revised 8/21/13 reveals: Up ad lib with walker, goes off and leaves it sitting frequently. Unsteady gait, psychotropic meds, history of falls, risk for falls. Use walker for stability, while ambulating - remind (resident) if (he/she) is up without it. Maintain room and pathways free of clutter. Quarterly fall assessment done, if fall, monitor for injuries. Bed alarm on at night(d/c'd 8/22/13) Review of fall careplan revealed it lacked a new intervention after the fall on 10/15/13. Review of the Fall Risk Assessment revealed: Dated 8/8/13 score of 20. (a score of 10 or higher is at risk.) Dated 10/31/13 score of 20: (a score of 10 or higher is at risk.)	F 280		

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A review of nurses notes, dated 10/15/13 at 9:00 AM, recorded: "found on floor near bed. No apparent injury or skin tears, no bruising noted. Stated "well I'm just sitting here on the floor": BP 123/79, HR 88, R 20, No c/o pain. Neuro checks sheet started. Dr. and DPOA notified.

Daily charting after fall reveals vital and neuro checks remained WNL and pt did not develop injury or c/o pain related to fall.

Review of the Physician Fax Communications, dated 10/15/13, documented, "FYI, non injury fall, staff found sitting on floor near bed, had been sitting on side of bed. Signed by physician 10/16/13.

Review of the Event Report Investigation documented the following:

"10/15/13: Fall: found sitting on floor next to bed. Had been noted by nurse earlier was sitting on edge of bed folding blanket. Injury: none. Witness: none. Treatment provided: neuro checks. Care plan updated/new intervention Implemented: see CCP. Comments: unable to determine if [he/she] fell good chance [heshe] slid off bed. Freq. leaves walker sitting or lays it down and walks away. Very restless and agitated today." Event Report attached: "10/15/13 at 0900. Alert, pleasantly confused, resident at side of bed on floor. Was sitting on bed folding blankets, most likely slid off since [he/she] was sitting side ways at the time. Assessment done. No skin tears or redness noted. Resident states, "well I'm sitting on the floor". No bump or redness to head found, will start neuro checks. Vital signs within normal limits. No complaint of pain to bilateral extremities or head. Contributing diagnosis: dementia. Contributing internal factors

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present: restless and agitated. Current medications: antihypertensive, antidepressant, antipsychotic, diuretics, analgesic, PRN meds Haldol 10/14/13 at 10:00 AM, Ativan 10/14/13 at 5:30 PM, Vicodin 10/14/13 scheduled. New Interventions: "Monitor every 30 min x 30 hrs". Continue current interventions as goal was met: resident will have no major injuries related to fall. physician and family notified." Review of the investigation documentation reveals a lack of any witness statements for fall.

Review of the facility fall record, dated October 2013, recorded: "10/15/13 9:00 AM Description of event: resident was sitting on edge of bed folding a blanket, few minutes later found sitting on floor next to bed. [He/she] is unable to say what happened. Good chance that [he/she] slid off bed onto floor. Has be very restless and agitated. Will frequently leave walker sitting or lays it down on it's side then walks away. Injury: none. Treatment provided: neurochecks. Intervention implemented: Continue CCP- goal met - no unmonitored injuries. Physician and family notification: complete.

On 11/13/13 at 7:58 AM, observation of resident in bed, direct care staff assisted resident up for breakfast. Staff offered prompts and assistance for resident to dress. Room free of clutter.

On 11/13/13 at 3:57 PM, observation of resident in room, lying in bed with eyes closed. Call light in reach. Walker at bedside. Room free of clutter.

On 11/13/13 at 1:50 PM, direct care staff F stated, "[He/She] had been aware of a fall recently and what they do for [the resident] is follow her closely when she gets anxious and driven and provide 1:1 as able, but he/she

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reaches a point of agitation when you then have to back off and give space, but just keep an eye on him/her."

On 11/13/13 at 2:50 PM, direct care staff G stated, "[the residents] fall was from trying to sit on trash can to go to the bathroom, he/she missed the can and sat on floor. Staff was told to remove the trash can out of the room and [he/she] hasn't fallen since."

Direct care staff L, on 11/18/13 at 8:30 AM, stated "new interventions after a fall depends on why they fell, but we don't always have them. If we do, we get told in report. I don't remember anything new we did after the fall [the resident] just had on 10/15/13."

Licensed nursing staff D, on 11/18/13 at 8:37 AM, stated "After a fall we do an Incident report, update care plan with new interventions, investigate and nuero's if unwitnessed or hit head and chart for 72 hours. If there is no injury, then we don't put a new intervention...we may just do 30 minute checks but that's it...[he/she] is just choosing to sit on floor, so we just make sure [he/she] doesn't have any unmonitored injury from falls."

On 11/13/13 at 4:40 PM, Administrative nursing staff A, stated "the intervention implemented after the fall was that they monitored the patient as needed to complete the neuro checks and that since this resident is an up ad lib, there are no new interventions that can be done to prevent further falls." Staff A confirmed that there was no new intervention put on the care plan after fall on 10/15/13.

On 11/14/2013 at 1:36 PM, Administrative staff A

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confirmed that the nurse should place a new intervention on the care plan after a fall and that the care plan lacked a new intervention after 10/15/13 fall.

The facility failed to review and revise the plan of care with new interventions following a fall on 10/15/13 to prevent repeated falls for this resident.

- The POS (physician order sheet), for resident #29, dated and signed 10/01/2013, documented the following diagnosis of dementia, abdominal aortic aneurysm (a localized dilation of the wall of the aorta), and right hemiparesis (muscular weakness of one half of the body).

The significant change MDS (minimum data set 3.0), dated 09/10/2013, documented the resident needs extensive assistance with ADL's (activity of daily living), such as bed mobility, transfers, dressing, eating, and personal hygiene. It also documented functional limitation in ROM (range of motion) to the lower extremity on one side.

The CAA (care area summary), dated 09/17/2013, ADL functional/rehabilitation potential documented the resident was admitted to hospital to have a thoracic stent placed regarding the aneurysm. There was a problem with the spinal anesthesia (spinal chord infract) and the result being that he/she has a partial paralysis (the loss of muscle function, sensation or both) of the right leg. He/she is unable to walk and can transfer with assist to a wheelchair. The CAA lacked documentation of the use of a siderail for mobility purposes.

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The restorative care plan, dated 09/17/2013, documented the resident to have restorative range of motion at the frequency of 2 to 5 times a week, for 4 weeks, including active range of motion (AROM) and passive range of motion (PROM) to lower extremities.

Restorative Care progress notes documented the following:

11/7/13 no change in status of patient, continue passive range of motion to right lower extremity for maintenance at this time. Continue +2 assist for transfers as needed.

The restorative care flow record, dated 11/13/2013, documented to change restorative to maintenance only, to provide passive range of motion to the right lower extremity only. The plan of care, failed to evidence this change in range of motion.

Observation, on 11/18/2013 at 1:22 PM, revealed direct care staff F, performing passive range of motion. The resident started to do the exercises his/herself, lifting his/her right leg and bending at the knee. Direct care staff F performed passive and active range of motion combined.

On 11/14/2013 at 2:52 PM, Direct care staff J advised, "We do ROM when they are getting undressed and into their pajamas, then when we are giving showers the warm water helps warm up the muscles. We don't really chart it, it is something we do as part of their cares. Who is on a ROM or restorative program, we can find out, there is a book in the activity book. I don't think I know of any right now. "

On 11/18/2013 at 8:40 am, Consult staff H

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F 280	Continued From page 24 advised, "After the surgery, an Aneurysm repair, the lower extremity became nonfunctional. He/she has no active ROM and is now on restorative, he/she was functional before this happened. We do ROM to prevent contractures to the lower extremity." On 11/18/2013 at 5:00 PM, Administrative staff A, stated, "I know what you are talking about, I just forgot to change it on the sheet. This change happened on the 13th and you walked in on 14th." The facility failed to revise the care plan when the resident's restorative program changed to ensure continuity of care for the resident.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 27 residents, with 13 residents reviewed including 2 reviewed for bruising of unknown origin. Based on observation, interview, and record review, the facility failed to ensure adequate supervision, and/or assistive devices to prevent recurrence of bruising for these 2 residents (#17 & #26). Findings included: - Review of resident #17's, clinical record	F 323		

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revealed the resident admitted to the facility on 2/19/08.

The annual MDS (minimum data set), dated 11/4/12, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident required for ADL's (activities of daily living) extensive staff assistance for bed mobility and dressing only. Mobility per walker and wheelchair only. The resident had functional limitation in range of motion to lower extremity on both legs. The resident at risk for pressure ulcers, used a pressure reducing device for the bed, and had no other skin issues documented.

The quarterly MDS 3.0 dated 8/14/13, revealed the resident had changes in only, ADL's, required extensive staff assistance for dressing, and limited staff assistance for bed mobility. No further changes noted.

The CAA'S (care area assessment summary), dated 11/11/12, revealed the following: For ADL's: "Resident continue to use electric wheelchair, and uses walker in room. No significant change in functioning.

For Falls: Resident has had 1 fall since last annual. Score of 22 on fall risk , which is high. He/she does continue to walk with a walker, had a slow steady gait and otherwise uses electric wheelchair.

The facility Weekly Skin Integrity Review, documented the following:
On 11/6/13: Bilateral lower extremities with redness (chronic), Crack on right lower leg (chronic).
On 10/29/13: Bilateral lower extremities with

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cracks and redness (chronic).
On 10/22/13: No change from the 10/29/13 assessment.

The Weekly Bath Skin Assessments, completed by the CNA's (certified nursing assistant), dated 11/12/13, documented the following: "Chronic cracked skin right lower leg, bruise on the top of the left hand, and a red spot where flu shot given."

The Weekly Bath Skin Assessments, completed by the CNA's, dated 11/5/13, documented, "Bruise noted to right upper abdominal area."

The care plan reviewed 8/21/13, documented the following:

"At risk for skin issues related to incontinence, obesity, mobility, usually only takes one bath per week.
--independent of toileting-refused bladder retraining.
--Provide incontinence pads.
--Provide moisture barrier for use.
--encourage frequent self cleaning during day.
--skin assessments weekly.
--use tubi-socks to lower legs."

Risk for fall/injury related to unsteady gait, impaired mobility, balance problem, obesity. Uses electric wheelchair out of room and walker in room. Gets in hurry and goes fast in wheelchair, cuts corner to close, etc. Frequently reminded to be careful
--Maintain room free of clutter as much as possible.
--Gripper socks.
--remind the resident call to call for assist prn [as needed]

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F 323	Continued From page 27 --Watch prn in wheelchair and remind the resident of safety issues prn. The plan of care failed to address occurrence of bruises of unknown origin and lacked measures for prevention. The physician ordered on 4/7/10, ASA, 81 mg (milligram), take 1 tablet by mouth twice daily. The nurses notes, dated 11/14/13 at 3:00 PM, documented the following, "Has approximately 1 cm [centimeter] by 1.5 cm pink/ purple area on back of left hand. Said he/she hit it on dresser. He/she is alert and oriented, so feel this is what happened." On 11/13/13 at 9:00 AM, the resident propelling self in a electric wheelchair in the hall. A bruise noted to the top of the left hand On 11/13/13 at 12:30 PM, the resident bed rail is up on the side of the bed by the wall. Unchanged from previous observation. The resident has a bedside dresser beside the bed. On 11/13/13 at 3:30 PM, the resident sitting in his/her room watching television. On 11/14/13 at 10:00 AM, the resident in electric wheelchair, doing exercises in the family room. On 11/14/13 at 2:45 PM, the resident ambulating self toward the bathroom with a walker. On 11/12/2013 at 12:59 PM, the resident reported, "I probably bumped it when turning at night." On 11/14/13 at 3:02 PM, direct care staff J	F 323		

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reported, "I didn't see any bruising, If I saw it I would tell the charge nurse, and then I would chart it on the bath sheet. They [the nurses] put interventions in place, and if we find out what caused the bruise, it would be taken it out so the resident would not get a bruise."

On 11/18/13 at 12:30 PM, direct care staff E reported, "The resident does not have any bruising. If he/she did, I would let the nurse know."

On 11/13/13 at 4:24 PM, licensed nursing staff N reported, "We write up an incident report for an unexplained bruise,the nurse would monitor until gone. Then we [the nurse] would notify the doctor and let them know of an unexplained bruise. We [the nurse] would place it on the treatment sheet to monitor till healed. We also update the care plan."

On 11/14/13 at 11:19 AM, licensed nursing staff D reported, "A bruise is charted on the shower sheets then monitored weekly, on the skin sheets, then put on the MAR and monitored every shift until healed. Review of the November 2013 TAR [treatment administration record] with the nurse revealed the resident not being monitored. "I guess we are not monitoring the bruise. We monitor a bruise until healed. We do an incident report, unless we know what happened, such as a blood draw or a reliable resident tells us what happened. We do daily reports in the morning and throughout the shift to pass along any information."

On 11/14/13 at 1:36 PM, licensed administrative staff A reported,
"On this resident, I know it is care planned for bruising on his/her legs. He/she is not careful in

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F 323	Continued From page 29 the electric chair. I don't know if the hands are on the care plan or not. The resident does not tell me what is going on. We need to ask him/her about what happened. The resident is able to tell you what happened. We would then determine what to do next. If he/she says something like hit on the dresser, we would chart in nursing note. If the bruise is not a one time thing, if it was not a fluke thing then we would care plan for bruising. They [the nurse] should monitor until it is faded. The facility policy, had a review date of 9/11 for Incident/accident; assessment, reporting, documentation documented the following; "Purpose: To provide appropriate and complete information relating to fall incidents and any injury to the body, skin tears, bruises. To aid in assessment, causes and prevention of incidents and related injury. Skin Issues: All skin tears/bruises or bodily injury, not occurring as a result of a fall must be reported on the Event form." The facility failed to provide this resident adequate supervision and/or assistive devices to prevent further bruising. - Review of resident #26's clinical record, revealed the resident admitted to the facility on 5/6/13, with the following diagnosis; dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), and anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues).	F 323		

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The annual MDS (minimum data set), dated 6/26/13, revealed the resident had short/long term memory deficit, and moderately impaired decision making. The resident with delirium; inattention and psychomotor retardation, behavior present and does not fluctuate. The resident required for ADL's (activities of daily living), total assistance for toilet use and personal hygiene; extensive assistance for transfers, walk in room/corridor, locomotion on/off unit, and dressing. The resident's balance is not steady, and functional limitation in range of motion to lower extremities bilaterally. Mobility per walker and wheelchair.

The quarterly MDS, dated 9/18/13, revealed the following changes; The resident with delirium; inattention and disorganized thinking, behavior present, which does not fluctuate, all other areas remained unchanged.

The CAA'S (care area assessment summary), dated 7/10/13, revealed the following: for cognition: The resident had a gradual decline. The resident has less interaction with staff, wife and roommate. Is in wheelchair majority of time for ambulation, shows little interest in any activities. For ADL's: the resident requires extensive assistance with 2-3 aides, and a gradual decline in all ADL's.

The Weekly Skin Integrity Review by the nurse documented the following:
On 11/12/13: Bruises, old bilateral hands
On 11/4/13: Bruises, old bilateral hands, skin tears left arm, treatment in place.
On 10/24/13: Bruises old, back of bilateral hands.
On 10/12/13: bruises. Diagram to document skin conditions , indicate new sites with an X (both

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F 323	Continued From page 31 hands circled). The Weekly Skin Assessment by CNA (certified nursing assistant) during a bath documented the following: On 11/13/13: documented on the back of the residents right hand, bruise on the back of the hand and a bruise between the thumb and first finger. (documented on the sheet as a lab draw). On 11/6/13: documented old skin tear, treatment in place. On 11/2/13: back of left hand with purple discoloration. On 10/23/13: back of left/right hand bruise noted. On 10/19/13: Bruising noted to the back of the right arm (2) and hand (3); and the back of the left hand had two bruises. On 10/17/13:Bruising noted to back of both hands, old. On 10/9/13: Bruise noted to back of the left and right hands. On 10/5/13: Bruise noted to the back of the left and right hand. The care plan reviewed on 10/2/13 documented the following: Potential for skin issues: --Related to incontinence, cognition, bruises easy due to anemia. --Weekly skin assessment. Self Care Deficit and risk for falls, related to mobility, cognitive deficits, lack of hygiene awareness, history of falls: --Requires max assistance of one to two aide to assist with bathing, dressing, hygiene and grooming. --walker for ambulation prn [as needed]. --allow enough time for the resident to assist with	F 323		

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ADL's.
--Break task down to manageable segments.
--Use wheelchair when unable to ambulate.

The plan of care failed to address the occurrence of bruising of unknown origin and lacked measures for prevention.

On 11/12/13 at 11:33 AM, observation of the resident evidenced purple bruises on the resident's right hand.

The nurses notes dated 11/13/13 at 3:05 PM, documented, "Nurse brought resident to Doctors room for lab draw, (H&H) with assistance from staff member. Nurse had successful 1st attempt, no blood return from resident's right wrist..." (The resident had the bruise on 11/12/13).

On 11/13/13 at 7:45 AM, the resident observed sitting in the dining room in his/her wheelchair, with a purple discoloration, approximately 2 cm [centimeters] by 2 cm, noted to the resident's top of hand, between the thumb and first finger.

On 11/13/13 at 5:00 PM, the resident sitting at the dining room table, purple discoloration noted to the top of the residents hand. The resident not observed hitting hand on the underside of the table.

On 11/14/13 at 8:00 AM, the resident sitting at the dining room table, in his/her wheelchair. Same purple discoloration noted to the top of his/her right hand, between the thumb and the first finger.

On 11/14/13 at 8:52 AM, the resident ambulated from his/her wheelchair to the toilet with rolled walker and gait belt, and staff assistance of direct care staff I and L. The resident with a

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approximate 2 cm by 2 cm purple discoloration to the right hand between the thumb and 1st finger.

On 11/14/13 at 9:06 AM, direct care staff I reported, "It [the bruise] has been charted on. The resident wheels around on his/her own sometimes, when in the mood. He/she will occasionally have a bruise. I will get the nurse immediately and let him/her look at the bruise. If he/she starts getting in a mood and wants to get up and we will put the resident in the recliner. The nurse will tell us in report if there is an intervention. We will let the nurse know, and they will put the information on our care plan sheet we have."

On 11/14/13 at 3:02 PM, direct care staff J, "No, I have not seen any bruising with the resident, I would talk to my charge nurse and go from there. The resident care sheet [similar to a CNA care plan], the charge nurse gives to us, and licensed staff A does the changes. If he/she is not here, then the charge nurse would make the changes. I don't recall sleeves on him/her, I will check on the other paper work."

On 11/13/13 at 4:24 PM, licensed nursing staff N reported, "The staff follow the care plans, and we have resident care sheets. We make copies and give them to the aides at beginning of the shift. We update them. If we have something which needs to be passed on, there is a notebook, kept in the break room. We write up an incident report, on unexplained bruises, and monitor until the bruise is gone. Then we notify the doctor and let them know. We put it on the treatment sheet to monitor till healed. Yes, we are up to date on the care plan."

On 11/14/13 11:19 AM, licensed nursing staff D

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F 323	Continued From page 34 reviewed the residents skin sheet, dated 11/13/13, which documented the bruise on his/her right hand from a lab draw, by licensed nursing staff N. Staff D also reviewed documentation in the nurses notes which evidenced, lab drawn from wrist area [the bruise is located in the area between the thumb and first finger]. "I would investigate a bruise. I have seen the resident propelling his/her wheelchair, and he/she did hit his/her hand. I would try a new intervention if I can figure it out. I chart the bruise, so as to make the investigation easier. Review of the resident's TAR (treatment administration record), by nurse D, at this time, revealed no monitoring of the resident bruising. On 11/14/13 at 1:36 PM, administrative nursing staff A reported, "The bruise is marked as a lab draw on his/her wrist. The resident had the bruise the day the survey started, and there was no documentation. We have some residents, and this resident is one, who will come to the table and will hit the table. He/she takes medications which will cause bruising, it is care planned. If they do a weekly skin assessment, the bruise will then be put there. If the resident does not it usually bruise, then we do an investigation and put on the TAR." The facility policy, had a review date of 9/2011, for Incident/accident; assessment, reporting, and documentation, documented the following; "Purpose: To provide appropriate and complete information relating to fall incidents and any injury to the body. ...g. skin tears, bruises. To aid in assessment, causes and prevention of incidents and related injury.	F 323		

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F 323	Continued From page 35 Skin Issues: All skin tears/bruises or bodily injury, not occurring as a result of a fall must be reported on the Event form." The facility failed to provide this resident adequate supervision and/or assistive devices to prevent further bruising.	F 323		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility identified a census of 27 residents. Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents and staff. Findings included: - During the environmental tour of the facility, on 11/18/13 at 11:30 AM, the janitor closet on the West Hall revealed base board missing along the wall and sheetrock damaged the entire length of the wall where it is missing (up to approximately 6-8 inches above the floor). There is a gouge in the wall approximately 2 feet long, and the wall by the sink has approximately a 2 foot square area of chipping paint. Maintenance staff M stated, on 11/18/13 at 11:50 AM, that he/she was aware of the needed repairs and maintenance and that it was a work in progress. The baseboard had been removed when the tile was replaced and never put back.	F 465		

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F 465	Continued From page 36 The facility failed to assure that the janitor closet on the west hall was safe, sanitary and a comfortable environment for residents and staff.	F 465		